Safety and Improvement Educational Resources

A toolkit for delivering safe, effective and person-centred care

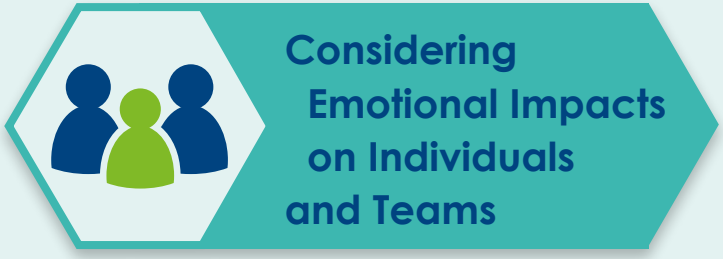
Enter

NHS Education for Scotland

Contents

Enhanced Significant Event Analysis

- Evidence shows that our use of Significant Event Analysis (SEA) as a team learning and improvement method could be more effective in supporting patient safety and practice performance.
- With support from the UK Health Foundation, NES has updated the existing SEA method to ensure 1. We consider the potential emotional impacts of events on practitioners and teams and 2. We take a systems-wide approach to analysing the event by identifying the interacting contributory factors between people, work activity and the wider environment so that greater insights into why things go wrong can be established, leading to more meaningful improvements being implemented by care teams.
- Supporting resources, including an updated SEA report format and entry-level e-learning, are available at: **www.nes.scot.nhs.uk/shine/.**

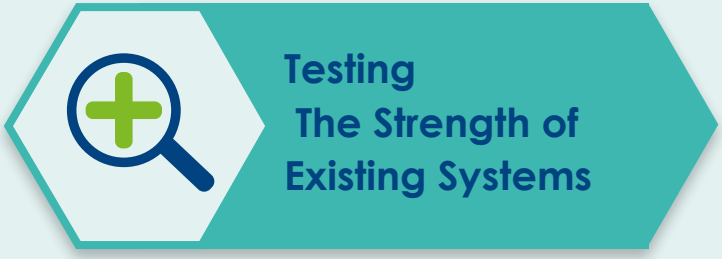


Safe Systems for Test Ordering and Results Handling

- Around 20% of significant events in general practice are related to systems for managing laboratory test results, making this a key patient safety priority.
- To help practice teams and NHS Boards learn from and improve system safety, NES has developed 'Good Practice Statements' and related educational resources.
- Building on this work, Healthcare Improvement Scotland has also developed resources in this area which can be accessed on the Scottish Patient Safety Programme Website (**http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/safety-across-the-interface**) and the Scottish Patient Safety Progamme Primary Care Community Site (**http://www.knowledge.scot.nhs.uk/spsp-pc/care-across-the-interface-(results-handling-and-comms)/results-handling.aspx**).
- Information on a NES Practice-Based Small Group Learning Module on this topic can be found at: **http://www.gpcpd.nes.scot.nhs.uk/pbsgl.aspx.**

Taking Action to Prevent 'Never Events'

- A 'never event' is a serious patient safety incident which is thought should never happen in healthcare if the appropriate preventative measures are in place. In acute hospitals a simple example might be removing the wrong limb or organ from a patient.
- NES worked closely with a range of general practice team members and safety experts to validate a core list of ten 'never events' and a supplementary list of other potentially serious safety incidents.
- The list of possible safety incidents can be useful for GP teams to reflect on the potential of one or more of these events to happen in the practice, test the strength of existing systems, and take appropriate action where necessary. Supporting materials can be accessed at: **http://bjgp.org/content/64/620/e159.** Additional information is available at: **www.nes.scot.nhs.uk/patient-safety/.**



The General Practice Safety Checklist

- Many significant events in general practice are related to 'checking' processes across the whole work system and the consequences associated with having inadequate systems in place e.g. drug expiry dates, emergency equipment, infection control, IT systems, clinical registration checks, patient confidentiality and mandatory health and safety issues.
- Working closely with frontline GP managers, nurses and doctors, NES has prioritised safety-critical hazards across the general practice environment and developed a comprehensive 'checklist' process to help teams take a systematic approach to related monitoring, learning and improvement.
- Although still in development, the prototype checklist can still be of use to practice managers and GP teams looking to strengthen their monitor and improve existing safety systems. The checklist can be accessed at: **http://bjgp.org/cgi/doi/10.3399/bjgp15X684865.**

Using 'Always Events' to Drive Improvement in the Patient Experience

- Listening to and acting on the concerns of patients and clients about the care they receive and expect is problematic in health and social care. For example, healthcare teams may think the findings from annual patient surveys are too vague to drive local improvements or distrust the results because of low response rates from patients.
- The 'always event' concept aims to bridge this gap by providing care teams and patients with a localised method of determining what is really important to patients and using this information to drive quality improvement.
- Some basic examples of 'always events' may include: *"I want all members of the practice team to show genuine concern for me at all times"* or *"I want to arrange appointments around my family and work commitments"*
- 'Always events' are developed by care teams based on feedback from patients and clients about what is really important to them every time they interact with health and care services.
- A set of criteria helps care teams to develop 'always events' that are feasible for them to potentially deliver on within the time and resource constraints of everyday practice. Practices choose the patient groups they wish to focus on, while the 'always events' developed are likely to be specific only to your local context.
- For more information visit: **http://bmjopen.bmj.com/content/5/4/e006667.full.**

A Safety Checklist for Early GP Specialty Training

- In the GP training environment there are a number of potential threats to performance, wellbeing and safety.
- Examples include: inadequate clinical supervision; lack of joint review of the management of complex clinical cases; limited feedback on drug prescribing performance; poorly developed attitudes and behaviour continuing unchecked e.g. lack of insight; trainees possessing different levels of clinical knowledge; inability to prioritise clinical workloads and manage time; variable quality of the learning environment in which trainees' work; and doctors-in-training being known to be susceptible to 'medical error'.
- Routine adherence to the use of a 'checklist' process may help GP supervisors, trainees and practice managers to prioritise and address the most safety-critical issues to be addressed in the early training period in the general practice setting.
- NES worked extensively with GP supervisors, practice managers and trainees to develop and validate a checking process based on the identified safety-critical topics to be covered.
- Examples of safety-critical domains and related issues to be covered include: prescribing safely; dealing with medical emergency; consulting safely; safe use of practice computerised systems; raising awareness of personal responsibility; and dealing with child protection issues.
- The checklist and a related self-rating scale for GP trainees can be downloaded on the NES website: **http://www.nes.scot.nhs.uk/patient-safety/.**

The Trigger Review Method (TRM)

- Occasional trigger review of electronic patient records can provide the GP team with important opportunities to identify patient safety-related learning needs and direct improvement efforts.
- By screening small samples of the records of high risk groups of patients, the team can detect and learn from 'incidents' or 'latent risks' that may be hidden in the records.
- Searching for specific high yield 'triggers' - such as 'abnormal blood results' or a 'recent out-of-hours visit' – potentially leads to a speedy and structured method of detecting incidents of interest and making judgements on what action should be taken.
- A typical review lasts on average about 2 hours which enables you to screen 25 records and reflect on the findings.
- Conducting a TRM can be used as evidence of a Quality Improvement Activity in specialty training and in support of medical appraisal, or for practice nurse continuing professional development.
- Further information and educational support can be found at: **http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/safety-culture.**

Independent Peer Review

- The NES approach defines peer review as the external evaluation of one element of an individual's performance by trained colleagues using a validated review instrument to facilitate developmental and unbiased feedback.
- Peer review can lead to the identification of learning needs and act as a 'double-check' on standards and opportunities for rapid improvement within practice.
- Participation in the NES independent peer review system by individual practitioners, care teams or NHS Boards can help to satisfy the governance requirements of some external bodies and is an effective means of quality assurance and confirming good practice, e.g. as part of quality accreditation, educational supervisor training, specialty training, professional appraisal and Continuing Professional Development (CPD).
- The educational approach to peer review designed by NES enables clinicians, managers and healthcare teams to submit written reports of SEAs and Criterion Audits/ QI projects for feedback from peer groups trained in the process. GPs can also submit videoed consultations for feedback under the same system. Additional information is available at: **www.nes.scot.nhs.uk/patient-safety/.**

Team Reflection on Safety Climate

- It is accepted that healthcare teams with a positive safety culture are more likely to learn openly and effectively from when things go wrong. The converse is true for a negative safety culture, which has been implicated as a contributory factor in many organisational failures worldwide, including high profile NHS incidents.

- The prevailing safety culture also influences the priorities of every health care worker and helps to shape their discretionary safety attitudes and behaviours.

- A strong safety culture is important to improving patient safety, staff wellbeing and practice performance. Building a positive safety culture is therefore strongly promoted as an important activity for all NHS organisations

- Safety culture is commonly defined as *"the product of individual and group values, attitudes, perceptions and patterns of behaviour that determine a team or organisation's commitment to safety management".*[1] Another well known definition is *'the way things are done around here'*.

- The term 'safety climate' refers to the measurable components of safety culture. Safety climate surveys typically require the workforce to complete self-report questionnaires anonymously on a periodic basis. They assess important aspects of safety climate in the workplace (e.g. perceived effectiveness of team-working, leadership or communication systems or the impact of workload and safety systems).

- NES worked with hundreds of GP teams to develop, test and refine 'GP-SafeQuest' - a 30-item, validated questionnaire specifically designed to be used in general practice and which is available via an online system administered by Healthcare Improvement Scotland: **http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/primary-care/safety-culture.**

[1] INSAG (International Nuclear Safety Advisory Group). Safety Culture. 1991;75-INSAG-4:1-44.

Promoting a Strong Safety Culture

Criterion Audit and Clinical Care Bundles

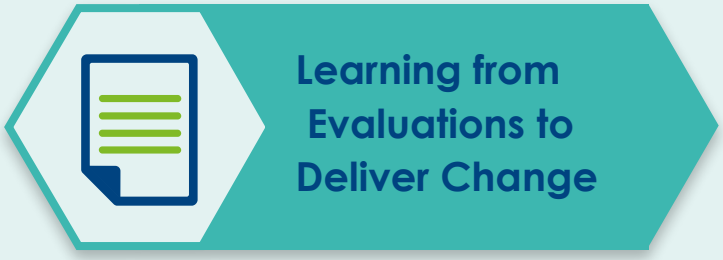
- Criterion based audit is a well established Quality Improvement (QI) method in healthcare, but is often poorly implemented.
- NES has researched this area for a number of years and developed guidance on undertaking effective audit for improvement projects for GP and nurse trainees and established practitioners and managers.
- The care bundle approach is strongly related to criterion audit in terms of the aspects of care that are being defined and measured for improvement, although there is a difference between how data are presented and acted upon (i.e. at the individual criterion level for audit, and the combined 'all or nothing' approach favoured by the bundle method)
- Further information can be found at: **http://www.appraisal.nes.scot.nhs.uk/media/145815/Audit-Booklet.rtf.**

Practice Based Small Group Learning (PBSGL)

- PBSGL is an innovative approach to CPD for GPs that originated in Canada and has grown rapidly in Scotland within the last decade.
- NES GP educators are at the forefront of PBSGL development and research.
- Over 30% of all GPs in Scotland are now involved in PBSGL and the number continues to grow each year.
- A number of PBSGL modules are of direct relevance to improving the quality and safety of patient care, and enhancing professional and practice performance. Additional information is at: **http://www.gpcpd.nes.scot.nhs.uk/pbsgl.aspx.**

Learning from the Scottish Patient Safety Programme in Primary Care (SPSP-PC)

- In recent years, NES has led on the design and development of many safety and improvement methods and has also worked in an advisory role with colleagues in Healthcare Improvement Scotland (HIS) who are leading on the implementation of SPSP in primary care.
- As part of this process, NES has been involved in jointly evaluating SPSP with HIS and NHS Boards which includes studying the impact of programme interventions to reduce avoidable harms and improve the reliability of care systems.
- A number of reports are now available on different aspects of the programme as it has spread across NHS Boards throughout Scotland.
- The early learning from these evaluations will be of interest to frontline care teams taking part, local NHS Board leaders, national policy makers and international colleagues with an interest in patient safety in primary care.



Educational Resources in Development

NES Educational Resources in Development:

- **Enhanced SEA**
  - Digital App for health and social care teams
  - Train-the-Trainer workshop materials
  - Dedicated website and e-learning
- **Human Factors and Ergonomics (HFE)**
  - Entry-level e-learning module
  - 'Taster' workshops to raise awareness of HFE
- **Practice Based Small Group Learning**
  - Never Events
  - Always Events
  - Updating of HFE module

About This Resource

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This NHS Education for Scotland (NES) resource is available to Health and Social Care teams to help promote individual, collective and organisational learning. The main purpose of the tools and techniques described is to support everyday performance and wellbeing at work and help enhance the patient and client experience of care.

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **altformats@nes.scot.nhs.uk** to discuss how we can best meet your requirements.

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For further information see: **www.nes.scot.nhs.uk/patient-safety/**

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